

Service Area Plan

Department of Health

Local Chronic Disease and Prevention Control (44016)

Service Area Background Information

Service Area Description

Chronic Disease Prevention and Control includes two broad areas of local health department services; 1) prevention of chronic diseases before they occur through health promotion and disease prevention activities and 2) provision of clinical services for indigent patients with chronic diseases (provided by some local health departments).

Health promotion and disease prevention services are activities directed to reducing mortality and morbidity or premature mortality and morbidity associated with chronic diseases such as heart disease, cancer, diabetes, arthritis, asthma and stroke. The main focus of these programs is to reduce controllable risk factors such as high blood pressure, cholesterol, smoking, physical activity and obesity. This includes a wide range of services to assist citizens such as blood pressure and cholesterol screening and counseling, social marketing programs focusing on improving physical activity, nutrition and smoking prevention/reduction, working with community partners to assess the community's health status and prioritize issues, implementing environmental and policy changes, and providing traditional health education classes. This includes services to groups and individuals that are clinic, community or home-based, and the local health departments' Breast and Cervical Cancer Screening Program that provides clinical breast exams and screening mammography to detect breast cancer in the presymptomatic stage. Pap smear testing is performed to detect precancerous changes in the cervix.

A few local health departments provide acute and chronic medical care for indigent adults needing medical care for chronic disease conditions such as diabetes and hypertension. This may include laboratory and pharmacologic support, follow-up, and referrals to private specialists for complex medical conditions.

Service Area Alignment to Mission

This service area is directly aligned with the VDH mission to promote and protect the health of Virginians. The fundamental purpose of chronic disease prevention and control efforts is to promote and protect the health of all Virginians through various environmental and policy interventions intended to reduce the burden of chronic disease.

Service Area Statutory Authority

The Code of Virginia §32.1-11 provides that the Board of Health (VDH) may formulate a program of preventive, curative and restorative medical care services to be provided at the district or local level. Clinical preventive services are focused on the indigent, and the Code provides that VDH shall define the income limitations within which a person shall be deemed to be medically indigent.

In addition, the Code of Virginia § 32.1-11.3 provides that VDH shall formulate a program of patient and community health education services to be provided by the Department on a district or local basis. The Code notes that the program shall include services addressing health promotion and disease prevention and shall encourage the coordination of local and private sector health education services.

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Service Area Customer Base

Customer(s)	Served	Potential
Adults (age 50+) in need of colorectal cancer screening	60,229	1,204,563
Adults who do not engage in physical activity	68,189	1,363,366
Adults who had a heart attack	9,220	184,390
Adults who had a Stroke	5,588	111,752
Adults who smoke cigarettes	63,978	1,279,552
Adults with Arthritis	71,521	1,430,470
Adults with Asthma	21,233	402,305
Adults with Diabetes	20,116	402,305
Adults with disabilities	44,701	894,011
Adults with High blood pressure	70,963	1,419,242
Adults with High cholesterol	93,872	1,877,422
Men (age 50+) in need of prostate cancer screening	21,069	421,369
Patients – Clinical-based services	9,280	239,000
School children	68,000	371,354
School nurses	184	1,373
Women (age 40+) in need of breast cancer screening	5,851	433,709

Anticipated Changes In Service Area Customer Base

- Any new legislation related in some way to chronic disease could affect the service area customer base. For example, an increase in the state tobacco excise tax could reduce the number of new smokers and existing smokers.
- Most of the chronic disease prevention activities exist due to grants received. As grants are received or discontinued, the actual customers served will change based on the availability of funding for chronic disease programming and outreach.
- Needs and priorities are driven by changes in the aggregate risk behavior of individuals in communities such as the current trends in tobacco consumption, over consumption of calories leading to obesity, sedentary lifestyle, and promiscuous sexuality.
- Increased longevity and growth in the elderly population, and growing demand for services for chronic disease management, could increase the customer base.
- Increasing understanding of the value of prevention is increasing the demand for information and services.
- Increasing demand for indigent care due to immigration of foreign-born persons, will require adaptations to language and cultural differences.

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Service Area Products and Services

- Community Assessment
 - Applying the science of epidemiology, using health outcome data and demographics in assessing the community's health.
- Public Information, Education and Social Marketing
 - Increasing knowledge, changing attitude and behaviors regarding chronic disease prevention and control through:
 - Providing leadership to a community partnership to design and implement initiatives such as Heart Health month education and awareness events.
 - Implementing media campaigns: Providing web based information through various links with the Centers for Disease Control, U.S. Department of Health and Human Services, U.S. Department of Agriculture, etc.
- Chronic Disease Screening Services
 - School-based health screening program for height/weight/BMI-for-age, education and individual counseling and case management for overweight public school children with parent permission.
 - Blood pressure, cholesterol, and glucose screening, and health consumerism education.
 - Marketing and conducting health screenings for hypertension, high cholesterol, elevated glucose levels and health risk appraisals at numerous work sites, health fairs and churches. Follow up with risk reduction education programs for participants.
 - Lipid panel and Hemoglobin A1C screening in various venues.
 - Every Woman's Life Program – an early breast and cervical cancer detection program for women 50-64 years of age in which health department staff provide screening for these two specific diseases and referral to other health care providers for diagnostic follow-up and treatment.
- School Based Services and Education

Several health departments work in partnership with local schools to implement programs that are directed to improve knowledge, change attitude and behavior regarding chronic disease prevention such as:

 - Work with school districts in providing after school education programs in the area of chronic disease prevention; health department staff present programs on nutrition, exercise and smoking prevention including educational programs designed with identified Virginia Department of Education Standards of Learning
 - Sun/safety/skin cancer prevention initiative implemented in middle and high schools utilizing display board, brochures, sun safety practice survey and related incentives (sunscreen and Chapstick).
 - Individual counseling and case management for students with chronic diseases (asthma, diabetes-Type I and Type II, cardiac, etc.).
 - Implement Guidelines for Managing Asthma in Virginia Schools including instructing school personnel in proper use of nebulizers and educate physical education teachers to control environment for asthmatic children on high-pollen days.
- Community Partnerships

Many health departments participated in community partnerships are usually community driven initiatives targeting a specific chronic disease related issue such as:

 - A community walking program in partnership with Parks and Recreation or other organizations providing pedometers and other incentives to continue health enhancing activity.
 - Nutrition and physical activity education in child care centers. Child Care Health Consultants,

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Service Area Products and Services

who are Public Health Nurses, work with staff of child care centers on nutrition and physical activity issues.

- Educational classes targeting the prevention and control of a number of chronic diseases, risk factor reduction and safety with senior groups and retirement communities.

- Nutrition and physical activity programs implemented as an after-school program with the YMCA and Boys and Girls Clubs.

- **Community Based Programs and Services**

Several local health departments initiate chronic disease prevention programs using a variety of local, state and federal resources.

- **Access to Chronic Disease Medical Care**

- Provide assistance with application to FAMIS, FAMIS Plus and Medicaid.

- Partnerships with local physicians, free clinics and community health centers to provide medical care, access to medications and referral to specialty care.

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Factors Impacting Service Area Products and Services

- Lack of adequate funding for chronic disease prevention and control is the number one challenge to local health departments. Money influences both the availability of staff to develop and conduct programming and the publication of necessary materials to do so.
- Changes in scopes of services from funding sources may change the specific types of chronic diseases addressed.
- Access to care is impacted due to increasing costs, transportation and limited services
- Enhanced diagnostic technologies identify more diseases and therefore increase demand of chronic disease services.
- Developing partnerships that are necessary for implementation, funding and sustainability.
- School cafeterias offering poor nutritional choices.
- School focus is on SOL testing and school administration is hesitant to use instructional time to address chronic disease issues.
- Reaching target populations with effective prevention messages. Few youth and adults are willing to give their free time to prevention activities.
- Inadequate health information sharing among health care providers/collaborative entities. Care is inconsistent, often episodic and different care providers rarely have a complete picture of the patient resulting higher costs, poorer outcomes.
- Health disparities persist in some regions of the state such as Appalachian Region, and among certain racial groupss.
- The need for parents to be educated or “actionated” that healthy kids make healthy adults.
- Drug abuse and misuse especially around pain management with prescription drug leading to overdose deaths becoming a growing epidemic.
- While there are many private weight loss programs and gyms for physical activity, there are few low cost programs. Many people cannot afford the fees associated with the private programs.
- Programs need to be community based with the concept of coordination of all partners involved in the reduction of morbidity and mortality of chronic disease.
- Access to care is a broader concept than merely having a payment source for health care or community health care centers. Access to care encompasses the individuals understanding of how to access care and navigate the bureaucratic systems. Many individuals need mentors to assist them in obtaining health care, advocate for the individual and assist them in understanding and complying with health care recommendations and healthy lifestyle behavior activities.
- Pediatricians in general seem reluctant to treat children found as prehypertensive/hypertensive in many geographic areas. There appears to be a need for a system to refer pediatric clients for further evaluation and treatment.
- No time or staff for involvement in chronic disease activities. Need of a health educator in all health districts.
- Growing restaurant individual meal portions. Some do have selections for low calorie or low carbohydrate diets, but those selections do not have much appeal for the average person.

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Anticipated Changes To Service Area Products and Services

- Federal Preventive Health and Health Services Block Grant funding was proposed to be eliminated in the Presidents' 2006 federal budget. Changes to this funding source could cause the elimination or reduction of services.
- Assessments of community health needs are continuous. Services adapt to gaps in health care, citizen demand, local leadership interest and local resources available.
- Research that identifies behavioral and co-morbidity indicators of chronic disease such as the relationship of obesity to diabetes.
- Continued immigration of foreign-born persons will require adaptations to language and cultural differences.
- Changes in disease priorities
- Changes in the environment and human behaviors that promote the development of chronic diseases.
- Advanced technology permits early detection of chronic disease conditions such as cancer detection by use of genetic markers, but will affect costs and availability.

Service Area Financial Summary

Resources for Local Health Department Chronic Disease Prevention and Control include \$3.6 M in State General Funds (GF) and \$8.2 in Non-General Funds (NGF) each year; 30 percent and 70 percent respectively.

The largest portion (33 percent) of the Non-General Funds are federal grants allocated to local health departments through VDH and include the Public Health and Health Services Block Grant, Cardiovascular Health Project, Arthritis Interventions, Tobacco Use Control Project, Asthma Control Program, Diabetes Prevention and Control Project and the Breast and Cervical Cancer Screening Program Grant. Thirty-two percent of the NGF come from local governments as either match funds for State GF allocated to local health departments or 100 percent local funds. These unmatched local funds make up 12 percent of the total local funds allocated for chronic disease prevention and control. Thirty percent of the NGF are service related fee revenues from a variety of sources including Medicaid, Medicare, other insurance and patient self-pay. The balance of the NGFs, five percent is made up of other grant/foundation resources received by local health departments for chronic disease prevention.

	<u>Fiscal Year 2007</u>		<u>Fiscal Year 2008</u>	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	\$3,210,592	\$7,637,106	\$3,210,592	\$7,637,106
Changes To Base	\$390,142	\$569,437	\$390,142	\$569,437
SERVICE AREA TOTAL	\$3,600,734	\$8,206,543	\$3,600,734	\$8,206,543

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Service Area Objectives, Measures, and Strategies

Objective 44016.01

Provide local leadership for chronic disease prevention and control.

Local health departments are frequently the unifying voice in their communities for chronic disease prevention and control, working through strong relationships with other governmental agencies and nongovernmental organizations in order to the development of public/private partnerships that facilitate improved prevention and control of chronic disease. These efforts lead to better coordination of existing knowledge being applied more effectively in the community. Many of these chronic disease prevention activities have either been at the work site, agency-based, school-based or community-based. However, more are becoming faith-based as well. These efforts range from educational to developing policies that promote healthy environments. This local health department leadership role is consistent with the Board of Health's focus on chronic disease prevention and with VDH statutory mandates. Local health departments possess the expertise in these regards as most health departments have master's degree trained individuals in policy, planning and chronic disease prevention.

This Objective Supports the Following Agency Goals:

- Provide strong leadership and operational support for Virginia's public health system.
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- Promote systems, policies and practices that facilitate improved health for all Virginians.
(This objective is also aligned with Virginia's long term objective to inspire and support Virginians toward healthy lives and strong, resilient families.)

This Objective Has The Following Measure(s):

● **Measure 44016.01.01**

Percent of local health departments with an active chronic disease prevention partnership.

Measure Type: Input

Measure Frequency: Annually

Measure Baseline: 56% of local health departments had an active chronic disease prevention partnership (FY05).

Measure Target: 80% by end of FY07

Measure Source and Calculation:

Data contained in the Local Health Department Annual Report will serve as the basis for calculating this measure

Objective 44016.01 Has the Following Strategies:

- Establishment of chronic disease prevention projects in each district, in collaboration with public, private and non-profit partners, which are responsive to community needs and local resources and leadership.
- Work with partner stakeholders on prevention activities such as outreach through early prevention and intervention with children. A focus could be placed on school health education and physical education activities by working with local school divisions or target worksites in order to reach the adult population. This type of approach could help influence policy and environmental decisions, and would promote healthy aging.
- Older adults could also be targeted in collaboration with the local Department for the Aging.
- Effectively educate the public about chronic disease prevention.

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Objective 44016.02

Provide local health outcome data and epidemiology support to help frame the chronic disease problem and develop strategies at the local health department level.

Local health departments have access a wide array of health outcome data through the VDH Center of Health Statistics, Virginia Center for Healthy Communities, Center for Disease Control and multiple other sources that can be very valuable in the development of chronic disease prevention plans; be they community-based, school-based, work sites, faith-based or agency based plans. Local Health Departments also have expertise in disease prevention and control and the epidemiologic expertise to apply local data and health trends in a meaningful way, using data to develop chronic disease prevention plans to guide program efforts that emphasize prevention measures and focus on specific targets for change and appropriate strategies for doing so. Data driven planning will show where the burden of disease is great and where disparities across populations are cause for concern. This objective is consistent with the Board of Health's focus on chronic disease prevention and control, and agency policy that provides that local health departments be involved in community health assessments.

This Objective Supports the Following Agency Goals:

- Promote systems, policies and practices that facilitate improved health for all Virginians.
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- Collect, maintain and disseminate accurate, timely, and understandable public health information.
(This objective is also aligned with Virginia's long term objective to inspire and support Virginians toward healthy lives and strong, resilient families.)

This Objective Has The Following Measure(s):

● **Measure 44016.02.01**

Percent of local health departments with a plan to address a chronic disease condition in their community.

Measure Type: Input

Measure Frequency: Annually

Measure Baseline: 56% of local health departments provided chronic disease related data that contributed to the development of a plan to address a chronic disease condition in the community (FY05).

Measure Target: 80% by end of FY07

Measure Source and Calculation:

Data contained in Local Health Department Annual Report will be used as basis for calculating this measure.

Objective 44016.02 Has the Following Strategies:

- Provide training to all district epidemiologists on chronic disease epidemiology.
On an as needed basis, access outcome data through the VDH Center of Health Statistics, Healthy Communities Atlas, and Centers for Disease Control.
Provide epidemiologic expertise to apply local data and health trends in a meaningful way, using data to develop chronic disease prevention plans to guide program efforts that emphasize prevention measures and focus on specific targets for change and appropriate strategies for doing so.

Objective 44016.03

Improve access to basic chronic disease medical management and access to affordable medications.

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There are a few local health departments directly involved in providing general medical care to indigent citizens through chronic disease prevention clinical services. Some of these operate a pharmacy providing access to some of the more frequently used medications. In addition, several district health departments work with local partners such as free clinics, hospital foundations, or community health centers to improve access to care. This objective is consistent with the Board of Health's focus on chronic disease prevention and control, and agency policy that provides that district health departments be involved in community efforts to assure access to basic medical care.

This Objective Supports the Following Agency Goals:

- Collaborate with partners in the health care and human services system to assure access to quality health care and human services.
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- Promote systems, policies and practices that facilitate improved health for all Virginians.
(This objective is also aligned with Virginia's long term objective to inspire and support Virginians toward healthy lives and strong, resilient families.)

This Objective Has The Following Measure(s):

- **Measure 44016.03.01**

Percent of local health departments that work with a partnership group to improve access to basic medical care services.

Measure Type: Input

Measure Frequency: Annually

Measure Baseline: 56% of local health departments were involved in efforts to improve access to chronic disease medical care services as of FY05.

Measure Target: 80% by end of FY07.

Measure Source and Calculation:

Data contained in the Local Health Department Annual Report will be used as the basis for calculating this measure.

Objective 44016.03 Has the Following Strategies:

- Study underserved populations (those living at or below the 200% FIPL) in collaboration with the Department of Medical Assistance Services, the Virginia Primary Care Association and local free clinics.
Participate in efforts to address unmet basic medical care needs in the community.